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Ms. Morales,

UnitedHealthcare (UHC) is pleased to have an opportunity to offer thoughts and suggestions regarding Rhode Island's (RI) Accountable Entity (AE) Initiative. The goals, objectives and models for attaining the strategic vision – better integrated care, improved health outcomes and more efficient use of state resources are consistent with our ongoing work and we are excited to be part of this new initiative.

General Comments on the Overall Accountable Entity Program

Feedback on the intent, strategic vision, goals and overall approach to the Accountable Entity Program.

We are particularly pleased to note the Executive Office of Health and Human Services' (EOHHS) recognition of the need for flexibility to develop and test new partnership models inclusive of innovative new strategies. As a long-standing participant in the Rhode Island Medicaid program, we look forward to continuing to work with the State to achieve common goals and offer recommendations premised on learnings from RI's AE pilots.

An overarching recommendation is that EOHHS leverage the expertise and experience of its contracted MCOs to ensure efficient and timely implementation of the initiative. Looking to the MCOs and their years of experience will ensure timely achievement of goals and objectives. At the same time, given the innovative nature of this initiative, sufficient time will be needed to allow MCO's and AE's to evolve their respective roles and responsibilities.

Premised on experience throughout the nation, we urge the state to consider the following as essential

core competencies needed of AEs:

- An ability to achieve a high level of clinical integration to ensure the flow of information across providers. Integrated care delivery requires contracting with a diverse group of providers – who may not traditionally have worked collaboratively or may not have the tools needed to quickly and accurately share information;
- Interest in, and capability of, assuming risk (up and down side) premised on prior experience and or planned development of data and analytic tools necessary to track and manage costs of care;
- Experience working with community based organizations and others well versed in the social determinants of health including referral and follow up mechanisms for individuals utilizing these services; and
- Technical abilities and competencies needed to track individual and systemic health care quality and utilization, to measure performance and track total cost of care to determine savings.

The State is encouraged to leverage the capabilities, expertise and tools that have been developed by contracted MCOs to achieve the goals of paying for value; coordinating physical, behavioral, and long-term health care; rebalancing the delivery system; and promoting efficiency, transparency, and flexibility. In particular, EOHHS is encouraged to look to the experience and competencies of MCOs in managing long term care services and supports. Leveraging this experience may best ensure achievement of the State's goals and objectives for more efficient delivery of LTSS waiver services.

Comments Related to the Five Pillars of the Accountable Entity (AE) Program

1. EOHHS Certified Accountable Entities and Population Health

UHC has made tremendous advances over the past few years in addressing the very challenges highlighted by EOHHS. These include:

- Moving from fee-for-service to value informed by practice goals and experience;
- Incorporating accountability measures and providing technical assistance to practices to advance their skills to be able to manage a variety of value based partnerships ranging from quality incentives to partial risk to total cost of care; and
- Creating a strong emphasis on Population Health to best address, support and promote healthy outcomes for those with complex health needs and exacerbating social determinants.

Based on these experiences UHC offers the following suggestions when refining AE certification requirements and establishing future relationships between MCOs and AE's:

1. **NCQA Certification.** It is strongly recommended that the MCOs and AE's be allowed to independently evaluate and certify practices as appropriate, capable and interested in participating as part of integrated care delivery networks and risk based payment models. While NCQA certification is a valuable tool, it is not necessarily an indicator of a practice's readiness to manage risk. The specific responsibilities of Rhode Island's AEs, and the contractual relationships between the AE and MCO, require independent oversight of practices rather than reliance on NCQA. As a result UHC recommends flexibility in the requirements for practices to become NCQA PCMH Level 3 certified and authority for MCOs to work with AE's in evaluating primary care practice readiness.

2. **Population Health.** The roadmap contemplates that the AEs will be responsible for coordination and integration of community-based services. MCOs typically use population risk registries to identify gaps in care and specific utilization profiles. Availability of this information – and communication of this information in a reliable and timely manner between the MCO and the AE will be of critical importance and must be an integral part of the AE certification requirements. Additionally the Roadmap contemplates that AEs will be responsible for coordination and integration of community based services such as long-term services and supports waiver benefits. Each AE should be evaluated for the capacity and experience with administering coordination activity such as ad hoc coordination of home and community based activities of daily living such as home health aides and other in-home supports.

3. **Integration of Behavioral Health and Medical Care**. AE certification must include an in depth assessment of integration of behavioral health and medical care through integrated service delivery networks. These integrated networks, to be of optimal efficacy, must also include linkages with providers and services supporting social determinants of health. The State is encouraged to identify and address statutory or regulatory barriers that might hinder sharing of behavioral health information with non-behavioral health providers, to support comprehensive, integrated care.

4. **Financial Readiness Assessment.** We would encourage EOHHS to consider the addition of a financial readiness assessment to the certification process for AE's taking on more sophisticated

valued based purchasing models such as up and down side risk and/or managing the total cost of care. AEs should be evaluated for financial strengths and be held to the same or similar solvency requirements as risk bearing entities. For example, EOHHS should evaluate AE's experience with budget development, performance benchmarking, capturing total cost of care and developing baseline utilization trends. Risk bearing requirements should include financial viability, minimum reserve requirements to cover claims costs, operating cash flow and financial statement reviews. Taking a disciplined approach to certifying AE financial readiness will assist with mitigating potential failures in the system.

2. *Progressive Implementation of Alternative Payment/Total Cost of Care Methodology*

Attribution is of critical import, especially as reimbursement evolves to total cost of care. UHC urges the state to consider mechanisms that ensure clear and consistent attribution at the AE, MCO and PCP level. Attribution is critically important for both the core AE's as well as the specialized AEs (please see section on specialized AE's for recommendations on attribution).

The attribution methodology employed must be sufficiently sophisticated to be able to track and attribute enrollees to their PCP and to be able to monitor PCP movement with respect to changes in AE affiliation. This is especially important under a total cost of care model. The tools to attribute individuals to their PCP and the PCP to the AE must be sufficiently evolved to allow for proper attribution, determination of costs and overall program management. EOHHS is encouraged to assure that these capabilities are in place at the outset.

3. *Progressive Implementation of Alternative Payment/Total Cost of Care Methodology*

EOHHS is urged to leverage the existing capabilities of its contracted MCOs to promote and continue an ongoing evolution toward adoption of value-base contracting models. Importantly, EOHHS is urged to provide both MCOs and AE's sufficient time to evolve working relationships and capabilities. The following comments are premised on UHC's experience with value-based payment models. Over $3.7 billion, or 22.4%, of UHC's Medicaid dollars are currently in value based arrangements with providers throughout the Nation.

Shared savings contracting based on a total cost of care budget is new, and to some degree foreign to many practices, and moving to a risk agreement too quickly could negatively impact the provider

organization, compromise access to care and risk not achieving total cost of care targets. To ensure success UHC recommends that EOHHS incorporate the following into the AE roadmap:

Flexibility in implementation design: We encourage EOHHS is to allow MCOs the flexibility to work with providers to align advanced payment model with provider's skills and interests. This facilitates a more stable program and allows MCOs to meet providers where they are in the evolution of their practice transformation and provide technical assistance customized for the practice's goals in advancing toward more sophisticated alternative payment models. We premise this recommendation on considerable experience with value based contracting across the nation that has yielded positive outcomes such as reductions in emergency room visits and hospital admissions, and improved performance on quality measures.

Additional time to move to full risk arrangements: EOHHS notes that some organizations may move toward risk more quickly (given prior experience). UHC recommends that allowances be made in the program structure to accommodate and support AE's that move more slowly. As many states have learned, health care delivery transformation from fee-for-service to value based payment takes times, significant investment and practice level culture change. The process of developing and implementing APM's may vary based on individual provider practices' capabilities, goals and desire to take on more sophisticated payment models. The sophisticated analytics required to support clinical activity, risk stratification and patient outreach and follow up takes time to develop and will vary depending on the practice's starting point, complexity and availability of technological and other supports and the capital available to invest in practice transformation.

The requirement that risk include meaningful downside shared risk or full risk within three years of any MCO contractual arrangement is likely overly ambitious for some, if not most, providers**.** While there should be goals for advancing provider's tolerance for managing risk to ensure continued progress – there must also be flexibility for AE's that are not prepared to engage at this level of risk within this time period. Additional flexibility is also likely to increase the number of providers that would be willing to pursue participation in APM models. EOHHS might wish to track progress; capabilities and quality metrics over time to ensure continued evolution of practice capabilities and to assure that any movement to this level of risk does not endanger health, access or quality.

4. *Implementation through contractual partnerships with Medicaid Managed Care Organizations*

UHC appreciates the recognition of the role and expertise of MCO's and the need for MCOs and AEs to be complementary rather than duplicative. UHC does however recommend that EOHHS consider the following recommendations regarding requirements for MCO – AE contractual relationships.

Impact on Existing Contracts: UHC urges the State to provide contracted MCOs leniency in terms of time allowed to amend existing contracts to reflect final AE certification decisions, timelines, reporting structures and other joint responsibilities.

Quality Scorecard: UHC appreciates the work that has gone into the quality scorecard and the importance of an aligned set of measures to promote ease of data collection and reporting, particularly at the provider level. Flexibility is recommended in terms of unique quality metrics identified by MCOs in collaboration with contracted AEs. This allows for the customization of the strategic partnership between the MCO and AE and the development of meaningful incentives to drive quality and efficiency.

Alternative Payment Model Timeline: The Roadmap proposes a fairly aggressive timeline to encourage movement from fee-for-service to alternative payment models. The requirement that participating AE's be in qualified APMs with MCOs on January 2018 may be ambitious – and leeway is recommended to accommodate evolving systems, models and varying practice level capacities.

As noted above, working with providers where they are, in terms of readiness for various APMs—not where we expect them to be, and thoughtfully advancing practice transformation is critically important. We recommend that EOHHS allow contracted MCOs the flexibility to work with AEs to develop APM's that reflect providers' readiness to assume financial risk.

Network: As proposed, EOHHS expects the Medicaid provider network to be the mixed responsibility of the AE and the MCO. Given the experience and expertise of MCO's in network development and contracting, EOHHS is urged to allow MCO's sufficient flexibility in working with AE's to determine the most appropriate division of responsibilities.

Data and Analytics: UHC is supportive of efforts to leverage robust data solutions such as all-claims databases and health information exchange engagement to enhance the availability and sharing of data within the delivery system. We are also cognizant that this is an ongoing initiative and that

time must be allowed to ensure development of appropriate capabilities and technologies to share data across MCO and AE's and within AE's.

As noted in the draft road map, a detailed plan for division of responsibilities related to data analytics will be required. It is recommended that EOHHS look to their contracted MCOs as lead entities well suited to help AE's to develop the tools needed to accomplish the following data-dependent activities:

- Identification of high risk patients and high volume areas of inappropriate variation that significantly drive costs. With identification AE's will be able to prioritize and address those areas that will most significantly impact costs and quality; as well as help them develop an effective payment structure strategy;

- Management of referrals to specialists, academic centers and other high cost specialized care units; and

- Integration of data from all participating constituents including hospitals (EHRs, financial, operational, patient satisfaction and other source systems), employed physicians, affiliated physicians (not employed by the AE), post-acute care (e.g. SNF, IRF/LTCH, Home Health, Hospice) and payers (claims, utilization and cost data).

Reporting Requirements: To ensure consistency of reporting and utility of information gathered for aggregate or statewide reporting and evaluation, it is recommended that reporting templates, definitions and templates be standardized across the system. This will ensure intra-MCO consistency and reliability and will ensure that statewide reports will be meaningful.

5. Infrastructure development & performance based incentive payments

To ensure consistency of reporting and of payments made to AE's UHC offers the following suggestions:

AE Corporate Structure and Governance. Care must be taken to ensure that the corporate structure and governance requirements for AEs are not overly burdensome resulting in attention paid to meeting these requirements instead of focusing on efforts to ensure engaged providers able to work together to achieve desired cost and quality outcomes.

Readiness Review. To ensure the provision of appropriate supports, and to be able to most accurately measure progress over time, it is recommended that a readiness review be conducted for each AE for each of the eight domains. This readiness review can then be followed by careful tracking of competencies over time with commensurate reporting to ensure progression at both the MCO level and statewide.

Comments related to the Specialized AE Pilot Programs

Feedback on the intent, strategic vision, goals and overall approach to the Specialized AE Pilot Programs

We would strongly encourage EOHHS' reconsideration of the use of the specialized AE program as a vehicle for administering and coordinating care and services to members with Long Term Services and Support (LTSS). As a starting point, prior to certification of these AE's, it is recommended that EOHHS consider integration of LTSS waiver services as part of broader MCO responsibilities to best promote coordination and integration and ensure provision of services in the most efficient and effective manner. Full integration will require that rates be commensurate with responsibilities inclusive of appropriate incentives to re-balance the system to encourage community placement over nursing home placement. It is only when the LTSS system is integrated in to managed care and the AE initiative matures that we would recommend the implementation of the Specialized AE pilot program.

We are prepared to work directly with EOHHS to ensure LTSS program success and provide any assistance in program reform recommendation for the administration of the LTSS program in managed care.

Attribution: Attribution for non-IHH enrollment must follow the PCP rather than the health home. This becomes especially important if the Type 2 model is allowed to sunset. To ensure consistency with broader AE's, attribution must first go through the PCP and then be linked with the AE. By attributing individuals to their PCP, MCOs and AE's will be better able to track individuals, assure quality and meet total cost of care targets.